State Of Arizona Board of Podiatry Examiners
"Protecting the Public's Health"
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Barry Kaplan, DPM; Joseph Leonetti, DPM; Barbara Campbell, DPM;
M. Elizabeth Miles, Public Member; John Rhodes, Public Member; Sarah Penttinen, Executive Director

Janice K. Brewer
Governor

BOARD MEETING MINUTES

April 11, 2012; 8:30 a.m.
1400 West Washington St., B1
Phoenix, AZ 85007

Board Members:	Barry Kaplan, D.P.M, President Joseph Leonetti, D.P.M., Member Barbara Campbell, D.P.M., Member M. Elizabeth Miles, Secretary-Treasurer John Rhodes, Public Member
Staff:	Sarah Penttinen, Executive Director
Assistant Attorney General:	Marc Harris

The Agenda for the meeting is as follows:

I. Call to Order

II. Roll Call

III. Approval of Minutes
a. March 14, 2012 Regular Session Minutes.

IV. Review of Administrative Law Judge Decision (NOTE: This is a time-specific agenda item scheduled for 8:30 a.m.)
a. 11-43-B – Elaine Shapiro, DPM: Review of ALJ recommended decision regarding allegations of habitual substance abuse; use of controlled substances for other than accepted therapeutic purposes; violation of stipulated agreement with Board, and failure to report criminal charges pursuant to A.R.S. §32-3208.

ALL REMAINING AGENDA ITEMS ARE NOT TIME-SPECIFIC AND MAY BE CONSIDERED AT ANY TIME DURING THE MEETING.

V. Review, Discussion and Possible Action –Review of Complaints
a. 09-49-C – Stanton Cohen, DPM: Any conduct or practice which may be harmful to a patient due to unprofessionalism and failing to administer local anesthetic during a wound cleaning.
b. 10-19-M – Lewis Freed, DPM: Practice below the standard of care for improper surgical correction of a hallux valgus deformity; failure to disclose malpractice lawsuit on license renewal.
c. 10-20-M – Luke Cicchinelli, DPM: Practice below the standard of care for performing surgery on the wrong limb.
d. 10-25-C – Scott Maling, DPM: Practice below the standard of care for improper treatment of foot pain.
e. 11-05-M – Stanton Cohen, DPM: Practice below the standard of care for improper surgery.

VI. Review, Discussion and Possible Action – Probation / Disciplinary Matters
a. 08-03-C – Elaine Shapiro, DPM: Monthly update.
b. 08-44-C – Alex Bui, DPM: Monthly update.
c. 09-17-B – J. David Brown, DPM: Monthly update.

VII. Review, Discussion and Possible Action on Administrative Matters

The board returned to Regular Session at 9:02 a.m. There was brief discussion as noted in the transcript. The board then considered and voted on the recommended Findings of Fact, Conclusions of Law, and Order.

MOTION: Ms. Miles moved to adopt the Findings of Fact one through 18 as written in the Administrative Law Judge's recommendation. Dr. Leonetti seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

MOTION: Ms. Miles moved to adopt the Conclusions of Law one through nine as written in the Administrative Law Judge's recommendation. Dr. Leonetti seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

MOTION: Ms. Miles moved to adopt the recommended Order of the Administrative Law Judge and revoke Dr. Shapiro's license. Mr. Rhodes seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by roll call vote.

Following the conclusion of this matter Mr. Munns departed and Mr. Harris remained to provide legal counsel to the board for the remainder of the meeting.

ALL REMAINING AGENDA ITEMS WERE NOT TIME-SPECIFIC AND WERE NOT REVIEWED IN THE ORDER IN WHICH THEY APPEAR IN THE MINUTES.

V. Review, Discussion and Possible Action –Review of Complaints

a. 09-49-C – Stanton Cohen, DPM: Any conduct or practice which may be harmful to a patient due to unprofessionalism and failing to administer local anesthetic during a wound cleaning.

Dr. Campbell was recused as she was the physician investigator for this case. Dr. Cohen was present with attorney Bruce Crawford. Dr. Campbell summarized the complaint investigation as follows: the board received a complaint from D.D. on behalf of her daughter G.W., a 12-year old female. The complainant stated that she took her daughter to Dr. Cohen on December 1, 2009 for correction of an ingrown toenail of the left big toe. She said the patient developed an infection which was treated with medication purchased Mexico. On a follow-up visit with Dr. Cohen the complainant alleged that Dr. Cohen did not provide local anesthetic to the patient's toe before cleaning the surgical site. The complainant also stated Dr. Cohen was generally "unprofessional" in his demeanor and verbal statements made to the patient.

Dr. Campbell reviewed Dr. Cohen's written response which she stated was much more detailed than the chart notes that were submitted. G.W. had been a patient of Dr. Cohen since August of 2008. Dr. Cohen has treated the patient for multiple foot and toe fractures. In June 2009 he performed a matrixectomy on the patient's right big toe. The patient never returned for any follow-up visits following that procedure. The next office visit was on December 1, 2009. At that time Dr. Cohen performed a matrixectomy on the left big toe, submitted tissue for lab testing, and the patient was given antibiotics and written postoperative instructions. The complainant contacted Dr. Cohen's office on December 4 stating the patient was in extreme pain. Dr. Cohen was unavailable and his staff instructed the patient's mother to follow the postoperative instructions and if they could not wait until Dr. Cohen returned to the office they should seek care at an urgent care center. Dr. Cohen's staff later followed up with the complainant and confirmed the patient's follow-up appointment for December 9. The patient was seen on that date and Dr. Cohen noted that the patient did not have a bandage over the toe and was wearing flip-flops. The patient had not gone to urgent care but it was noted that the patient's mother had medicated her with Tramadol which was purchased in Mexico. Dr. Cohen noted that there was a scar along the border of the nail which indicated that the patient had not been performing proper soaks and dressings. The patient admitted that she had not done all of the soaks that she should have been. Dr. Cohen noted at that time that the lab had not performed sensitivity testing and he became concerned that the patient was developing MRSA. He changed her antibiotics from Clindamycin to Cipro. The patient's mother alleged that the infection was due to Dr. Cohen's care. Dr. Cohen was concerned that the infection may have

been brought into the patient's home by her mother who works in a criminal detention facility. Dr. Cohen also noted that he chose not to anesthetize the surgical site prior to cleaning it because of the patient's prior extreme agitation with injections; he felt the injection would be more traumatic than the actual procedure. Dr. Cohen noted that he cautioned the patient many times that she would experience some pain during the procedure. He also feels that the debridement would not have been necessary if the patient had followed the postoperative instructions. The patient never returned to Dr. Cohen after this.

Dr. Campbell stated she had spoken with the complainant regarding an e-mail message which was sent to Dr. Cohen asking for an apology. The complainant confirmed that she did receive a written apology from Dr. Cohen. The complainant told Dr. Campbell that she gave her daughter the option to decide whether or not she wanted to return to Dr. Cohen and her daughter declined. Dr. Campbell reviewed that the complainant is an LPN and chose to medicate the patient herself with Tramadol which is not recommended for patients under the age of 16. That medication is a controlled substance which requires a prescription, and it is illegal to bring this medication from Mexico without a prescription. Dr. Cohen was also concerned that the patient might be diabetic due to her weight, infections, multiple fractures and sensitivity to pain. He had requested appropriate tests to determine if she was diabetic but the patient's mother declined to have those tests completed. Dr. Campbell concluded by saying that it seems apparent Dr. Cohen may have acted in a way that was inappropriate and unprofessional to the patient's mother. However, she does not feel that there was any danger posed to the patient or any conduct which was harmful. Dr. Cohen did send a written apology to the patient and her mother. She believes Dr. Cohen was upset over the patient's noncompliance with the postsurgical instructions along with a previous history of the patient not returning to his office following procedures. Dr. Campbell does not believe there was any violation in this case.

Dr. Kaplan reviewed the allegation as stated in the investigation report as follows: "Any conduct or practice which is or might be harmful or dangerous to the health of the patient." He feels that the written apology is a separate issue but he feels Dr. Cohen acted appropriately with the apology. Dr. Leonetti stated he feels the issue with the complainant medicating the patient with Tramadol is not pertinent to the care provided by Dr. Cohen. He added that he understands Dr. Cohen's perspective in this matter regarding the patient being so sensitive to any type of injection, and he feels it may be a bit of a gray area contemplating the pain caused by giving an injection versus debridement of the wound without anesthetic. Dr. Leonetti stated he feels Dr. Cohen did the best he could, but if he was a little gruff with the patient he has acknowledged that with his apology to the patient. Dr. Leonetti does not find any violation in this case. Ms. Miles added that she feels the behavior may have been inappropriate but does not rise to the level of a violation, and she was pleased to see the apology given to the patient.

MOTION: Dr. Leonetti moved to dismiss this case finding no violations. Mr. Rhodes seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

b. 10-19-M – Lewis Freed, DPM: Practice below the standard of care for improper surgical correction of a hallux valgus deformity; failure to disclose malpractice lawsuit on license renewal.

Dr. Freed was present without an attorney. Dr. Dedrie Polakof was the investigator for the case and was present. Dr. Polakof summarized the complaint investigation as follows: the board received a malpractice report from PICA, (the report was received on March 25, 2010), indicating that a claim had been filed against Dr. Freed by patient C.K. The nature of the claim was stated as, "Hallux valgus; contracture involving lesser toes; subluxation of lesser MPJ's. Surgery was performed and patient did well initially. At one point she was noted to have been walking on her foot, and several of the pins were bent; these were removed at that visit. She was seen at one point after falling. X-rays demonstrated maintenance of her correction, but she suffered a non-displaced fracture of the third metatarsal shaft, which healed uneventfully. At her last visit, she was noted to have continued swelling involving the second toe; patient then moved out of state. She alleges her bunion was not repaired and she required further surgery."

Dr. Polakof noted that this case had been previously reviewed by the board on June 9, 2010 as follows: PICA notification of claimed filed on March 21, 2007; claim against Dr. Freed dismissed with prejudice

with $0 settlement. However, Dr. Polakof noted that Dr. Freed did not disclose this matter on any of his previous license renewal applications. The first allegation as stated in the present case is practice below the standard of care for improper bunion correction. Surgery was performed on the patient on February 21, 2006. The procedure was a modified McBride repositional proximal osteotomy, modified Hibbs, and hammertoe correction of toes two through five with MPJ reconstruction. Fixation was accomplished with the use of a 4.5 cannulated screw from the first into the second and third metatarsal's in a lag fashion. On digits two through 5, a 0.045 K-wire was placed across the PIPJ and MPJ. Dr. Polakof stated she attempted to contact the patient to interview her but was unable to do so because the patient has moved out of state. Dr. Polakof did confirm with PICA that the patient had additional surgery with another physician. The malpractice claim settlement date was February 22, 2010.

Dr. Polakof stated that Dr. Freed was asked why he had not disclosed the malpractice action on any of his license renewal applications. Dr. Freed explained in a written statement that he had never been served with the legal complaint in this matter so he was not aware that he was being sued for malpractice. However, Dr. Polakof found a letter in the file from the patient's attorney dated March 15, 2007 which was sent to Dr. Freed's address of record at that time advising him that they were representing patient C.K. Dr. Kaplan reviewed the content of that letter with Dr. Polakof and confirmed that the letter did not advise that a lawsuit had been filed, it only stated that the attorney was representing the patient. Dr. Polakof agreed but added that Dr. Freed had also been contacted by PICA regarding this matter. Dr. Kaplan stated that PICA may have known but it cannot be determined if Dr. Freed was aware that an actual claim had been made with PICA. Dr. Polakof noted that in the patient's chart there were copies of medical literature and documents which indicated a legal defense strategy for this patient, and she questioned why those documents would be in the patient's chart if Dr. Freed did not have knowledge of a lawsuit. Dr. Leonetti asked Dr. Polakof to confirm her findings regarding the surgical procedure. Dr. Polakof stated that she found no problems with the surgical procedure that was done by Dr. Freed.

Dr. Kaplan clarified that there were two separate issues in this case. One was the allegation of practice below the standard of care for improper bunion correction; the second was for failure to disclose a malpractice lawsuit on license renewal applications. The allegations would be considered separately. Dr. Kaplan stated he feels the allegation regarding the practice below the standard of care is not substantiated. Dr. Campbell and Dr. Leonetti agreed. Dr. Kaplan asked Dr. Freed to provide an explanation as to why he had not disclosed this matter on his license renewal applications. Dr. Freed stated that he was not aware of the second allegation in this case until approximately 2 weeks ago when he received a call from Ms. Penttinen. (It is noted that a re-notice letter was sent to Dr. Freed on March 19, 2012 advising him of the second allegation for failing to disclose the lawsuit. He was asked to provide a written response no later than April 2. When no response had been received by that date, Ms. Penttinen contacted Dr. Freed at his office and asked him to fax a written statement which he did that day.) Dr. Freed stated Ms. Penttinen told him to put something down on paper and send it. He added that the reason he never disclosed this matter is because he never knew that he was being sued; he was never served. He stated that he received a call from the patient's attorney stating that they were going to sue him. However, when he called PICA he was told that a lawsuit had not been filed. The patient's attorney contacted him again and attempted to negotiate a cash settlement prior to filing a lawsuit. Dr. Freed contacted PICA again and they requested that he send them copies of the patient's records which he did. He believed there was a possibility that he was going to be sued, but the patient's attorney actually fired the patient as a client. At that time he contacted PICA again and was once again told that a lawsuit had not been filed. PICA advised him to re-contact them if you received any further information or contact from an attorney.

Dr. Freed stated he later received another letter from a different attorney advising that they were representing the patient; however, he still was never served with the legal complaint. He contacted PICA again, sent the patient's records to PICA again, and then never heard anything more about it. Dr. Freed apologized and stated that he did not make any attempt to hide anything from the board. He stated this patient's case was a very complicated procedure but he believes he did the procedure very well; he just never believed that he was being sued and that is why he did not disclose it to the board. Upon questioning from Dr. Kaplan, Dr. Freed stated that there had been a series of events in which he thought he was being sued but then he was never served and he thought it went away, and then it would come

up again, etc. He knows that at some point the lawsuit was technically filed but he was never served with the complaint. Dr. Freed had mentioned that an attorney named Bob Goldstucker had been involved and Dr. Leonetti asked him who that was. Dr. Freed said Mr. Goldstucker was a PICA attorney in Atlanta but stated that he never had legal representation, there were no expert witnesses obtained, and he believed the matter had just gone away. Dr. Leonetti stated that at some point a lawsuit was filed which Dr. Freed stated he became aware of through the present matter but had been previously unaware of. Dr. Kaplan referred to the date the claim was settled in 2010 and asked Dr. Freed if he had received any correspondence at that time from PICA. Dr. Freed stated he did not. Dr. Freed confirmed for Dr. Leonetti that he had submitted the patient's records to PICA, and upon questioning from Dr. Kaplan stated that was the reason why there were articles and medical literature in the patient's chart. Dr. Leonetti stated that he can understand a situation where an attorney sends a letter to a physician hoping that he matter will be settled before having to go to court, but if the physician does not respond then it just goes way.

Mr. Rhodes asked Dr. Freed if he had ever made any payment to the patient at any time, and Dr. Freed stated he did not. Ms. Miles pointed out that the question on the board's renewal application asks if the licensee has had a malpractice case served on them or filed against them within the last year. She stated that it is very possible for lawsuit to be filed but for the defendant never to be served; therefore, the defendant would never be aware of the lawsuit. The renewal application question does not ask if the licensee has any knowledge of a potential lawsuit. Ms. Miles continued and stated that she believes Dr. Freed may have had knowledge of a potential lawsuit but she does not believe that there is any evidence that he had actual knowledge of the lawsuit being filed. There also is no evidence that he was served. Ms. Miles added that she does not believe the board can consider the allegation regarding practice below the standard of care at this time due to previous review of this matter in 2010 at which time the board voted to dismiss the case finding no violations.

MOTION: Ms. Miles moved to dismiss the second allegation based on the wording of the license renewal question and the specific events of this case. Dr. Leonetti seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

c. 10-20-M – Luke Cicchinelli, DPM: Practice below the standard of care for performing surgery on the wrong limb.

Dr. Cicchinelli was present without an attorney. Dr. Dedrie Polakof was the investigator for the case. Dr. Cicchinelli confirmed for Dr. Kaplan that this incident occurred in North Carolina and that he was a licensed practicing physician at that time (not a resident). Dr. Polakof was present and summarized the complaint investigation as follows: The board received a malpractice report from PICA indicating that a claim had been filed against Dr. Cicchinelli by patient L.H. which was settled in favor of the patient. (The total settlement awarded to the patient was split 50-50 between Dr. Cicchinelli and the surgical facility.) The nature of the claim was stated as, "Patient was referred for evaluation of chronic pain in the right foot due to tear of peroneus brevis tendon and degenerative changes. Patient desired surgical correction which was performed on April 15, 2005. Due to a pre-operative positioning error and possible transfer of ink from 1 foot to the other, the operative procedure was performed on the left foot rather than the right foot as it should've been. Insured reported finding similar pathology on the left foot and did not realize that the surgery had been performed on the wrong foot until the procedure was finished." (It is noted that because this incident occurred outside of Arizona, the Arizona Podiatry Board was unable to obtain the patient's records due to a lack of subpoena authority.)

Dr. Polakof stated that Dr. Cicchinelli properly identified the correct limb in the pre-op area. However the patient crossed their feet and there was ink transfer to the incorrect foot. The nursing staff at the surgical facility then took the patient to the operative room and proceeded to prep and drape the wrong foot. Dr. Polakof stated that she had conducted some research regarding whether or not there was harm caused to the patient due to this type of incident. She stated that The National Institute of Medicine previously published an article entitled "To Err Is Human" regarding wrong-site surgery. Also in 2002 the National Quality Forum published an article which included "reportable events" in healthcare and described adverse events which were described as serious. According to that article in 2002 there was approximately a 12 1/2% chance of wrong-limb surgery around the world. Also in 2009 the Centers for

Medicare and Medicaid implemented the policy for wrong-site surgery prevention which later became a national standard. Dr. Polakof noted that this particular incident occurred prior to that national standard being implemented. However, she noted that all of the relevant literature ultimately places the responsibility for identifying the correct surgical site on the physician, although there was no standardization of protocol at the time of this incident. Dr. Polakof stated that she was undecided at this point as to whether or not there is a violation of statutes in this matter and she defers final opinion to the board members.

Dr. Cicchinelli confirmed for Dr. Leonetti that this incident happened in North Carolina in 2005. Dr. Leonetti asked Dr. Cicchinelli when he started practicing in Arizona, and Dr. Cicchinelli stated it was in 2008. Dr. Cicchinelli confirmed for Dr. Leonetti that the North Carolina podiatry board did not take any action regarding this matter. Dr. Leonetti stated that there is no question that the surgery was performed on the wrong limb, but his concern with this case is that this happened seven years ago in another state. He does not feel that there is any cause for concern for the Arizona board. Dr. Kaplan agreed. Dr. Cicchinelli stated that he appreciated the investigator's statements today regarding her conclusion that she could not make a determination whether the allegation was substantiated or not. However, he received correspondence from the board indicating the conclusion that the allegation was substantiated (referring to the complaint investigation report completed by Dr. Polakof). Dr. Cicchinelli added that the allegation states "practice below the standard of care for performing surgery on the wrong foot;" however, the board has a copy of the National Practitioner Data Bank report which states that no deviation from the standard of care was proven as well as his letter of explanation which clarifies the incident. Ms. Penttinen clarified for Dr. Cicchinelli that the allegation as stated in the investigation report is simply a clarification of what the board was investigating, and it does not mean that the board has already concluded that there was a violation. Dr. Cicchinelli stated that he understood but was concerned that the investigator seemed to have come to a different conclusion than the malpractice investigation which stated he had not deviated from the standard of care. Ms. Miles replied that he settled the case and there were no findings, but that doesn't influence the board's review one way or the other. Dr. Kaplan stated that because this incident occurred in North Carolina what the Arizona board would normally do is refer the case back to that state; however, the North Carolina board already made the determination that no action was necessary.

MOTION: Dr. Kaplan moved to dismiss this case finding no violations. Dr. Leonetti seconded the motion.

DISCUSSION: Upon discussion Mr. Rhodes referred to the complaint investigation report which stated that the allegation was substantiated. He was concerned that it may look bad that the investigator initially substantiated the allegation but then today stated she was undecided and the board ultimately has found no violations. Dr. Kaplan explained that the role of the investigator is to present the information and they may form an opinion; however, the investigator may change their mind and the final decision rests with the board members regardless of the investigator's findings. Dr. Leonetti pointed out that all legal action in this matter has been completed and upon this board's conclusion today, which appears to be a dismissal, the matter should be fully concluded in all ways. Dr. Leonetti agreed with Dr. Kaplan's comment that the board is not required to accept the investigator's opinion on any particular case. Dr. Kaplan pointed out that there was a similar case in recent months before the board where the investigator changed their opinion between the time they submitted their investigation report and the time it was presented to the board. Dr. Polakof added that when she submits her investigation reports her investigation is substantially complete but there are occasions when she does continue to follow-up on small details and other information prior to the board meeting. Dr. Kaplan offered to Mr. Rhodes that the investigator could submit an amendment to her investigation report if that would be helpful. Mr. Harris suggested that the board meeting minutes for this particular matter which will reflect this discussion would be sufficient.

VOTE: The motion passed by voice vote with a vote of 4-1 with Ms. Miles voting no.

d. 10-25-C – Scott Maling, DPM: Practice below the standard of care for improper treatment of foot pain.

Dr. Maling was not present. Dr. Dedrie Polakof was the investigator for the case and was present. She summarized the complaint investigation as follows: the board received a complaint against Dr. Maling from patient P.N. The patient went to Dr. Maling due to pain and pressure in her feet. Dr. Maling made custom orthotics for the patient. The patient states that she was very compliant with wearing the orthotics but they ruined her feet and caused more pain. The patient stated it was very difficult to walk and she eventually sought treatment with another podiatrist, Dr. Eulano, who told her that those orthotics had damaged her feet. Dr. Eulano is still treating the patient. The patient can now walk and stand but cannot do so barefoot and cannot take a shower without pain. Her condition is improving but the pain persists.

In review of the medical records, Dr. Polakof stated the patient first sought treatment with Dr. Maling on September 5, 2008. She was referred to him for ankle trauma. The patient frequently travels to Guatemala for volunteer work and hurt her right ankle while on one of those trips. She sought immediate medical care in an emergency room in Guatemala and upon returning to the United States she was referred to Dr. Maling by her primary care physician. Dr. Maling discussed multiple treatment options with the patient from conservative to surgical, and an MRI was performed on September 15, 2008. The MRI showed that there was tearing of the ATF and CF ligaments with avulsion fractures of the distal fibula as well as fraying and degeneration of the PT tendon on the left side. The patient elected to try conservative treatments and was given orthotics. Dr. Maling uses other labs; however, the patient wanted to go to a business called Arizona Walk Shop. A prescription was called in for a lateral ankle instability device. The patient never returned to Dr. Maling and he never saw the orthotics that were made. The patient was upset that Dr. Maling offered surgical options because she feels that surgery would have made her feet worse. The patient did receive treatment from her primary care physician which included manipulations of the feet and ankles. She also then went to Dr. Eulano who treated her pain with ultrasound, orthotics, and injections.

Dr. Polakof stated that Dr. Maling only saw the patient once in his office. He offered surgical intervention due to multiple repeated traumas of the ankles. He felt that the type of orthotic he prescribed would be helpful to the patient and does not know why that treatment was not successful. Dr. Polakof was able to interview the patient in person and look at the actual orthotics which were prescribed by Dr. Maling. Dr. Polakof also advised the board members that the patient was present and had orthotics with her from both Dr. Maling and Dr. Eulano. In summary, it is Dr. Polakof's understanding that the patient's complaint is that Dr. Maling's orthotics not only did not help but actually complicated her healing. Dr. Polakof confirmed for Dr. Kaplan that Dr. Maling had prescribed custom orthotics for the patient. Dr. Kaplan asked if Dr. Maling the use of lab that he normally uses. Dr. Polakof stated she did not know if Dr. Maling had one lab that he uses on a regular basis but he did send the patient to a place he does not normally use, (Arizona Walk Shop), because the patient requested it. She added that Dr. Maling has never seen the orthotics so he has not been able to evaluate if they were made correctly according to his prescription. Dr. Campbell asked if Dr. Maling had any contact with that facility after he sent the order. Dr. Polakof stated that he contacted that facility to make sure they understood his prescription because he had never used them before and was not used to working with them. Dr. Kaplan asked if there was a copy of the prescription in the patient's chart. Dr. Polakof stated she did not find a prescription, she only found a small description.

Regarding the MRI, Dr. Polakof stated there were many aspects involved in getting the MRI ordered, having it read by the radiologist, and getting the results back. There was a slight time delay; however, when he received the report he called the patient six days after the MRI was done to advise her of the results. The patient feels it took too long to get the MRI and the results back. Dr. Kaplan asked if Dr. Polakof had confirmed that the Arizona Walk Shop had received the prescription. Dr. Polakof advised that they had not received the original prescription so Dr. Maling had to send it a second time. Dr. Kaplan noted that it would be difficult for Dr. Maling in this matter because he never had an opportunity to see the orthotics for himself to make sure that they were done correctly. Dr. Polakof stated that that was Dr. Maling's main concern in this case. The board members did not have any further questions for Dr. Polakof.

The patient then addressed the board. She stated that her first concern was that when she first met with Dr. Maling he was very insistent that she have surgery as a first course of action. Because she was turning her ankle out, Dr. Maling told her that he was going to tighten some ligaments or muscles to make her foot more aligned. Dr. Maling apparently told her that she needed surgery on both ankles and that each one would require a six-month recovery period. She thought that sounded drastic but Dr. Maling was very insistent; however, she insisted on conservative treatment first. She also stated that with her trips to Guatemala every six months it would be extremely difficult for her to spend a year in recovery. The patient stated she knew nothing about the Arizona Walk Shop and did not request to go there. She stated that it took approximately one month to get the orthotics made and she did not know that she was supposed to take the orthotics back to Dr. Maling. She stated that she wore the orthotics "religiously" throughout the summer and fall. She then began to notice that when she got out of bed in the morning she had pain which would be alleviated after brief walking. This was shortly before one of her trips to Guatemala and during that trip she wore braces for extra stabilization of her ankles. After returning from Guatemala she no longer were the braces and began having extreme difficulty walking. Her primary care doctor then referred her to Dr. Eulano. Dr. Eulano apparently told her that her plantar fascia was being stretched too far in being torn. She states she is still being treated by Dr. Eulano for her foot and ankle problems. She stated that her foot condition has improved greatly since she stopped wearing the orthotics prescribed by Dr. Maling, although she does still have some problems.

The patient had provided her orthotics to the board members for them to visually inspect (both the orthotics prescribed by Dr. Maling and the ones prescribed by Dr. Eulano). In discussion with Dr. Kaplan, the patient again stated that she did not request to go to the Arizona Walk Shop; Dr. Maling sent her there. Dr. Leonetti asked the patient how many times she had seen Dr. Maling, and she said once or twice. Dr. Leonetti noted that there were very few records from Dr. Maling. Dr. Leonetti asked the patient if she was given the break-in instructions from the lab and if she had gone back to them for follow-up. She stated she was given the break-in instructions but was not told to return. She also stated that no one told her she needed to go back to Dr. Maling after receiving the orthotics. Ms. Miles asked the patient why she didn't call Dr. Maling or go back to see him when she realized she was having problems with the orthotics. The patient stated she decided to go to Dr. Eulano, but Ms. Miles pointed out that that did not occur for almost a year. The patient stated she started having problems in May just before one of her trips to Guatemala; when she returned on July 1 she made her appointment with Dr. Eulano. Ms. Miles asked the patient why she never contacted Dr. Maling to advise him that there was a problem with the product he had prescribed. The patient stated she did not have confidence in him because he was "surgery happy." She added that she felt a second opinion made sense. Ms. Miles asked the patient why, if she did not trust Dr. Maling, she would wear the orthotics he prescribed for seven months. The patient stated that the orthotics did not start bothering her until late May but at that time she was going to be leaving in just a few days to go to Guatemala. Dr. Kaplan asked the patient to confirm if the only conversation she had with Dr. Maling was to do surgery. The patient stated surgery was Dr. Maling's first course of action but she thought something else could be done and wanted conservative care first, then they discussed orthotics. The patient confirmed for Dr. Leonetti that the braces she wore were not provided by Dr. Maling; she bought them over the counter at the Arizona Walk Shop. Dr. Leonetti stated that he understands how the patient may have been uncomfortable with Dr. Maling and wanted a second opinion. He added, though, he does not feel the orthotics prescribed by Dr. Maling caused damage to the patient's feet. He stated they may have been uncomfortable but he feels if there were really a problem with the orthotics it would have come up in less than seven months. Dr. Leonetti continued and stated that if Dr. Maling ordered the orthotics he should have had the opportunity to inspect them to make sure that they were made properly.

Dr. Kaplan asked the patient who had dispensed each of the pairs of orthotics to her. The patient stated that the orthotics prescribed by Dr. Maling were dispensed to her by the Arizona Walk Shop. When asked about the orthotics from Dr. Eulano, the patient stated that they were dispensed from a physician in California. At that time the board members learned that the orthotics presented by the patient were not from Dr. Eulano. The patient stated that the orthotics made by Dr. Eulano were too short and she couldn't wear them. Dr. Kaplan explained to the patient that 99.9% of the time when a podiatrist prescribes orthotics the lab does not dispense them to the patient – the orthotics are sent back to the physician to inspect and dispense to the patient. In this case he does not feel that Dr. Maling is responsible for the fit of the orthotics because the lab dispensed them directly to the patient and he was

never given an opportunity to inspect them. Dr. Kaplan asked the patient if Dr. Eulano was aware that she had orthotics made by the other physician in California. The patient stated that he did but that she doesn't wear those or any orthotics anymore. Dr. Leonetti stated that he does not believe there is any violation in this case. He feels the patient may be unhappy with the orthotics she received which were prescribed by Dr. Maling but he never had a chance to correct them. Dr. Kaplan added that the patient did wear the orthotics and did not have a problem with them for seven months. The patient interjected and stated that she didn't know her feet were being damaged by wearing the orthotics until the damage was already done. Dr. Kaplan asked her how she knew that her feet were damaged by the orthotics. The patient stated that Dr. Eulano told her that her plantar fascia had been pulled in the wrong direction and caused damage. Dr. Leonetti stated that what the board is evaluating today is not statements made to the patient by Dr. Eulano but whether or not Dr. Maling did anything wrong regarding the orthotics.

MOTION: Dr. Leonetti moved to dismiss this case finding no violations. Mr. Rhodes seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

e. 11-05-M – Stanton Cohen, DPM: Practice below the standard of care for improper surgery.
Dr. Cohen was present with attorney Bruce Crawford. Dr. Dedrie Polakof was the investigator for this matter and was present. Dr. Polakof summarized the complaint information as follows: the board received a malpractice report from PICA indicating that a claim had been filed against Dr. Cohen by patient D.R. The allegation in this matter is practice below the standard of care for improper surgery. The date of the patient's first surgery was on August 29, 2007 for an arthroplasty of the right great toe. A second surgery was done on January 22, 2008 for an arthrodesis of the first metatarsal phalangeal joint of the right foot. A third surgery was done on June 3, 2008 for hardware removal. Patient has a history of diabetes and RSD in both hands, and was on morphine, Neurontin and hydrocodone.

Dr. Polakof summarized Dr. Cohen's records for this patient as follows: the initial office visit was on June 22, 2007 at which time the patient presented with pain in the first metatarsal phalangeal joint. The patient returned to the office on July 16 for a follow-up visit and expressed continuing pain. At that time Dr. Cohen reviewed conservative and surgical treatment options with the patient with the surgical option being an arthroplasty. On August 27 the patient had the pre-op visit and on August 29 an arthroplasty was performed. The first postoperative visit was conducted on August 31, 2007 and at that time the patient was doing well. The next time the patient was seen in the office was on December 13 at which time the patient expressed continued pain. Dr. Cohen discussed with the patient continued conservative treatment versus performing an arthrodesis procedure. The patient elected to go forward with that surgery. The pre-operative assessment was done on January 17, 2008 with surgery performed on January 22. The first post-operative visit was on January 24 at which time the patient stated there were still pain. In April of that year the patient stated she was having irritation due to the hardware. On May 28 the patient had a pre-operative evaluation for the third surgery which would be to remove the hardware that it been placed in her foot previously. Surgery was performed on June 3 and on July 10 it was noted that a hallux elevatus was starting. Dr. Polakof stated that she feels Dr. Cohen had an appropriate care plan for this patient; it was just an unfortunate surgical outcome. She does not believe the poor surgical outcome was due to any error in Dr. Cohen's surgical technique. Although the patient required additional corrective surgery which was done with another physician, she does not feel that Dr. Cohen's care of this patient constitutes any violations of podiatry laws. The board members did not have any questions for Dr. Polakof.

Dr. Cohen addressed the board. Dr. Leonetti asked him to provide a brief summary of what was going on with the patient at the end of his course of care with her. Dr. Cohen stated that on the patient's last office visit she was showing some elevation which he was concerned about. Dr. Leonetti asked him if there was a fusion at the first MPJ. Dr. Cohen said there was some bone fusion but not a complete fusion of the joint. Dr. Kaplan asked Dr. Cohen if that had been his intent in the surgical procedure and he said it was. Dr. Cohen stated that on the distal phalanx he did a wedge-osteotomy. Dr. Leonetti stated there are two issues: first is the IPJ which apparently had a fibrous fusion and he believes what Dr. Kaplan was asking is if that was Dr. Cohen's intent. Dr. Cohen replied that his intent was to do a wedge-osteotomy of

the distal phalanx but it resulted in a fibrous fusion. Dr. Kaplan clarified that he was speaking about the MPJ. Dr. Cohen stated at that joint the goal was an osseous fusion; the result was a partial osseous fusion and partial fibrous fusion. Dr. Kaplan asked Dr. Cohen where the plate was placed and Dr. Cohen explained that it was from the first metatarsal head to the dorsum of the proximal phalanx which is where he wanted the fusion done. He attached the plate using screws. Dr. Cohen continued and stated the distal phalanx was in a hallux abducto valgus position and was impinging on the second toe. At that point he made the surgical judgment that the patient would have been concerned post-operatively if he had not corrected that. He would normally do a wedge osteotomy of the proximal phalanx. However, the position of the hardware did not allow him to do that in this case so he elected intra-operatively to do the osteotomy on the distal phalanx. He stated he used a screw to hold the hardware place with the intent of removing that screw at a later date. Upon question by Dr. Kaplan, Dr. Cohen stated he used a first metatarsal phalangeal joint plate.

Dr. Kaplan asked Dr. Cohen about the patient seeking treatment with another physician which was Dr. Patrick Farrell. Dr. Cohen stated the patient was concerned about the elevation in her toe which he also was concerned about. He believes Dr. Farrell used a large K-wire to hold the whole complex straight and tried to put some mineralized bone matrix between the first MPJ to obtain secondary ossification in that area. The board members reviewed the x-rays which were submitted by Dr. Cohen which include pre- and post-operative films. Dr. Leonetti stated that on the post-operative films it appears that there is a large gap between the base of the proximal phalanx and the head of the first metatarsal. Dr. Cohen reviewed the film and stated that the plate is a very wide plate and is covering most of the contact site. Dr. Leonetti then asked Dr. Cohen to confirm if the reason the patient left his practice was because she was not happy with the position of the hallux because it was sitting up. Dr. Cohen stated that he could not speak for the patient. Dr. Leonetti asked if he'd had a discussion about that with the patient. Dr. Cohen stated he had not because the patient never told him she was not happy, she simply stopped coming back to the office. Dr. Leonetti asked Dr. Cohen if he was happy with the position of the hallux. Dr. Cohen stated he was not because it was elevated. Dr. Leonetti asked him if he was speaking about the IPJ or the MPJ and Dr. Cohen stated it was the IPJ where the wedge osteotomy was done. Dr. Leonetti asked Dr. Cohen what his suggestions had been to the patient to alleviate that problem. Dr. Cohen stated he would have to review his records but he believes he advised the patient to do exercises to stretch the toe into a plantar flexed position. He then planned to observe the patient to see how bad the dorsiflexion became and whether any further correction would be needed; because the patient had already had three surgeries he was hesitant to do a fourth surgery when other conservative measures could possibly improve the patient's condition. Dr. Leonetti confirmed that the contraction in the patient's foot was that the IPJ not the MPJ. Dr. Cohen stated that there may have been some dorsiflexion at the MPJ but most of his concern was at the IPJ. Dr. Leonetti stated that perhaps Dr. Cohen should have discussed the potential complications with the patient in greater detail and perhaps should have discussed with the patient a more comprehensive post-operative care plan. However, Dr. Leonetti stated that he does not find that there were any violations or practice below the standard of care in this case.

MOTION: Dr. Leonetti moved to dismiss this case finding no violations. Dr. Campbell seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

VI. Review, Discussion and Possible Action – Probation / Disciplinary Matters

a. 08-03-C – Elaine Shapiro, DPM: Monthly update.

Ms. Penttinen advised the board that although Dr. Shapiro's license is suspended at this time, her probation is still in effect so the monthly updates will still continue to appear on the board meeting agendas. Ms. Penttinen advised that the last quarterly report from Dr. Sucher was received in February 2012, so the next report will be due in May. Dr. Campbell asked Ms. Penttinen what the process is in relation to Dr. Shapiro's probation updates in the context of the board's review of the Administrative Law Judge decision earlier in the meeting and Dr. Shapiro's investigation case 11-43-B. Ms. Penttinen explained that once the Order in that case is executed and mailed to Dr. Shapiro she has 35 days in which to file an appeal or request for a rehearing or review. If no such appeal or request is received, then the order of revocation goes into effect on the 35th day and the monthly probation updates for case

number 08-03-C will no longer be needed. However, if Dr. Shapiro elects to file an appeal or request for rehearing or review, and then her probation remains in effect until that matter is concluded.

b. 08-44-C – Alex Bui, DPM: Monthly update.
Dr. Kaplan reviewed the monthly report submitted by Dr. Bui which states that there were no charts or records for any durable medical equipment billing for the month of March 2012. Dr. Bui's update letter also included a request for approval of two CME courses he has completed. Dr. Kaplan reviewed the reason why Dr. Bui was on probation which was for inappropriate billing for durable medical equipment and questioned why since that time Dr. Bui states he has not dispensed any durable medical equipment at all. Dr. Leonetti agreed that it doesn't make sense that Dr. Bui was dispensing a great deal of DME and then suddenly stopped completely. After brief discussion among the board members, it was decided that Ms. Penttinen would conduct an unannounced inspection at Dr. Bui's office. During that inspection she will pull random patient charts to review for any dispensing of durable medical equipment. Dr. Kaplan stated that following the meeting he would advise Ms. Penttinen of the specific billing codes to look for in the patients' billing records. Mr. Harris suggested to Dr. Kaplan that the board memorialize that decision with a motion.

MOTION: Dr. Kaplan moved to have Ms. Penttinen conduct an inspection at Dr. Bui's office and review at least 10 patient charts for durable medical equipment. Ms. Miles asked Dr. Kaplan if it was possible that Dr. Bui could be dispensing medical equipment but not using the specific codes in the billing paperwork, but that chart notes could indicate that DME may have been dispensed. Dr. Kaplan stated that if the proper billing code is not used then Dr. Bui would not get paid and it would be very difficult. Dr. Leonetti added that it could be possible Dr. Bui has another physician working in his office who does the dispensing. Ms. Penttinen stated that to her knowledge Dr. Bui did not have anyone else working with him, but it is possible that someone has joined his practice since the last time she conducted an inspection. Ms. Miles seconded the motion.
DISCUSSION: There was no further discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

MOTION: Dr. Leonetti moved to approve the CME hours submitted by Dr. Bui. Mr. Rhodes seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

Following review of this item Ms. Miles advised Dr. Kaplan that she must depart the meeting but wanted to provide her opinion on some of the remaining agenda items. She stated she had no concerns regarding the Executive Director's vacation leave or the hiring of temporary staff. However, she has concerns regarding putting information about medical assistants on the board's website. She feels that any statutes or rules posted on the board's website should be for only this agency; putting another agency's administrative rules on the board's website may be inappropriate or cause confusion and more information may be needed. Ms. Miles departed the meeting at 10:48 a.m. Any agenda items where Ms. Miles was not present are noted as such in these minutes.

c. 09-17-B – J. David Brown, DPM: Monthly update.
Ms. Miles was not present. Ms. Penttinen advised that the last quarterly report from Dr. Sucher was received in February so the next report will be due in the month of May. She has not received any reports of non-compliance. Dr. Leonetti asked whether Dr. Sucher was still obtaining quantitative values on Dr. Brown's drug tests. Ms. Penttinen stated that he is. Dr. Leonetti asked if any of those had been received yet and Ms. Penttinen advised that they should be included with the May progress report.

VII. Review, Discussion and Possible Action on Administrative Matters

a. Correspondence from Leon Cattolico, DO, regarding use of the AZ Board of Pharmacy's prescription monitoring program.

Ms. Miles was not present. The board members reviewed correspondence submitted by Leon Cattolico, D.O. regarding the Arizona State Board of Pharmacy's prescription drug monitoring program. Dr. Cattolico has requested that this board provide information to its licensees about the availability of that Pharmacy Board program. Ms. Penttinen clarified that healthcare regulatory boards are able to access that monitoring program as well as individual healthcare providers. During one of the meetings of agency directors in February a representative from the Arizona State Board of Pharmacy presented information about that program. That representative indicated that there are approximately 25,000 registered users who report into the database; however, less than 8% of physicians and healthcare facilities use it to query information about their patients. Therefore, the Pharmacy Board is trying to increase awareness about the availability of this program, particularly in light of the recent increase in prescription drug abuse. Ms. Penttinen stated that all of the Podiatry Board's licensees would be allowed to use that monitoring program.

Dr. Kaplan asked if there is a cost for using the program. Ms. Penttinen stated that the Pharmacy Board representative advised that there is a cost of approximately 2 dollars per query; however, they are absorbing that cost at this time. Dr. Leonetti added that his brother who is also a physician uses the program. It was slightly difficult getting registered but after that it is a very easy system to use. Dr. Leonetti asked if there are any concerns about HIPPA-protected information and if users of the program could go in and randomly look up information on people such as their neighbors. Ms. Penttinen stated that potentially it could happen; however, there are very strict penalties. Anyone who queries the system has to be able to prove a legitimate reason for querying a specific person. Ms. Penttinen stated that she is uncertain if there is any proactive monitoring for any misuse of the system or if it is done on a case-by-case basis upon the Pharmacy Board receiving a complaint of alleged misuse.

Dr. Leonetti stated his only question was how to distribute information about this program to the Board's licensees. Dr. Kaplan suggested that information could be posted onto the board's website and/or ask the state association to distribute the information. Dr. Leonetti added that there are licensees who are not part of the state association. Ms. Penttinen advised that the license renewal applications are going to be sent to all current licensees within the next few weeks and she could place an insert into each envelope with information about the program. Drs. Kaplan and Leonetti agreed with doing that and stated they also would like Ms. Penttinen to advise the state association. Mr. Harris advised that the board should document this with a motion.

MOTION: Dr. Kaplan moved to enclose an insert about the prescription monitoring program in the 2012 license renewal application mailings. Dr. Leonetti seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

b. Review and approval of 2012 license renewal application form.
Ms. Miles was not present. The board members reviewed the application form and instruction form. Dr. Kaplan reviewed a suggestion previously made by Ms. Miles regarding the application question about malpractice cases. Renewal application forms in previous years have asked the question, "Since your last application has a malpractice case been served on you or filed against you?" Ms. Miles had suggested adding language to that question to ask the applicant if they are aware of any impending malpractice litigation. (It is question 7.i on the application form.) Dr. Leonetti stated he is uncertain that it is a good idea to include the suggested language because it would be difficult to prove when a licensee became aware of any impending litigation. Mr. Harris stated that other healthcare regulatory agencies likely ask a similar question on their application and renewal forms and offered to review those documents. Ms. Penttinen explained that she had done so already and based the wording of this question on language used by other boards. There was brief discussion regarding the CME report page and Ms. Penttinen explained the words and numbers on the back of the bottom page which are spaces for her to document specific dates and the checklist of required documentation.

MOTION: Dr. Leonetti moved to approve the application form and instruction form as drafted by Ms. Penttinen. (The draft document does not include the language suggested by Ms. Miles.) Dr. Kaplan seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

c. CME approval request from the APMA for its 2012 Annual Scientific Meeting.
Ms. Miles was not present. Dr. Kaplan reviewed the CME approval request submitted by the American Podiatric Medical Association for their Annual Scientific Meeting which will be held August 16-19. The complete meeting will offer up to 26.5 CME hours.

MOTION: Dr. Kaplan moved to approve the CME request from the APMA. Dr. Leonetti seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

d. CME exemption request from William Accomando, DPM.
Ms. Miles was not present. The board members reviewed a letter submitted by Dr. Accomando which indicates that he has been having extensive spinal problems. Dr. Accomando stated that because of his spinal problems he has been unable to attend continuing medical education during the last year. He is requesting a waiver of his CME requirements for this year. Dr. Kaplan asked if an extension could be allowed. Ms. Penttinen clarified that a 60 day extension could be given if the board denied CME that was already completed. However, what Dr. Accomando is requesting is an exemption from completing the 25 hours due to physical disability. Dr. Kaplan stated that he has seen Dr. Accomando in person at a CME event and witnessed his physical condition, but he does not know if the board has the authority to waive CME requirements. Ms. Penttinen reviewed the board's statutes §32-829 which states that on written application the board may waive the CME requirements for a licensee who submit satisfactory proof that they are prevented from attending educational programs because of disability. Both Dr. Leonetti and Dr. Kaplan stated that they believe Dr. Accomando has a legitimate physical disability. Dr. Leonetti added that he did not agree with waiving the entire 25 hours and he believes Dr. Acconando should still complete the 10 hours which is allowed using Internet-based courses and journal reviews.

MOTION: Dr. Kaplan moved to waive 15 hours of CME for Dr. Accomando and required 10 hours via Internet-based courses or journal review. Dr. Leonetti seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

e. Discussion regarding adding information to the Board's website regarding scope of practice for medical assistants.
Ms. Miles was not present. Dr. Kaplan reviewed the comment Ms. Miles made prior to her departure from the meeting which was that she does not feel it is appropriate to have information for other healthcare professionals on our board's website. Dr. Kaplan asked Ms. Penttinen how frequently she receives calls or questions about medical assistants. She stated it's a rather infrequent occurrence and there have been two inquiries in the last six months. She thought that it might be helpful to be able to direct those inquiries to the website for them to download the information themselves and only wanted to present this topic to the board for their discussion and consideration. Dr. Leonetti asked Ms. Penttinen whether her intention was to place a scanned document containing the regulations on the Podiatry Board's website or simply put up a link to the websites for the Arizona Medical Board to direct inquiries to that specific website. Ms. Penttinen stated she could do it either way. Dr. Leonetti stated that he would not have any issue with placing a link on our website directing inquiries to the Medical Board website. The board members reviewed the scope of practice which was adopted by the Arizona Medical Board which is from the Commission on Accreditation of Allied Health Education Programs. Drs. Kaplan and Leonetti expressed concern regarding whether this particular scope of practice for MA's would include functions that would not be allowed in a podiatry office.

Dr. Leonetti asked if the Podiatry Board would need to include a scope of practice for medical assistants in its administrative rules. Mr. Harris advised that could be done. Ms. Penttinen then asked to clarify if inquiries she received should be directed to the Arizona Medical Board. Dr. Kaplan stated she should not refer them anywhere. Drs. Kaplan and Leonetti agreed that medical assistants could do things which are non-invasive. Dr. Leonetti asked if the board should have a policy regarding this and Ms. Penttinen advised that a Substantive Policy Statement could be written. Mr. Harris stated that it should be in the board's administrative rules. He added that a Substantive Policy Statement is not enforceable, therefore any guidelines should be in the board's rules. Ms. Penttinen advised that the board still needs to complete its rules change based on previous statute changes, so she could add this issue into that process. Dr. Kaplan asked when that rule change would take place. Ms. Penttinen advised that she needs to hire a rule writing consultant. She plans to hire Kathleen Phillips who will conduct a thorough examination of all of the board's rules as well as financial position; she will then develop the appropriate language for the necessary changes. Dr. Kaplan noted that he has asked Dr. Campbell to conduct research on the appropriate policies for medical assistant guidelines and she will report back to the board.

f. Review of new license applications:
   i. Mia Horvath, DPM.
   ii. Jessica Prebish, DPM.
   iii. Ryan Scott, DPM.
   iv. Andrew Straley, DPM.

The board members reviewed the complete license applications for each of the four physicians listed above and determined that there were no substantive deficiencies.

MOTION: Dr. Kaplan moved to approve the applications for each of the four physicians listed above and allow them to sit for the oral exam on June 13, 2012. Dr. Campbell seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

VIII. Executive Director's Report – Review, Discussion and Possible Action

a. Open complaint status report.

Ms. Penttinen reviewed the open complaint status report which shows that there are currently 61 open complaints including those reviewed by the board today. Nine cases have been assigned to investigators, three are ready to assign, and 24 are awaiting a response from the physician and subpoenaed documents. She advised that she has been staggering out the requested response dates and allowed extended response times in order to facilitate a more even workflow with processing those responses and records as they come in. This will also assist with assigning the cases to the investigators.

b. Request to hire part-time temporary administrative staff to assist with processing license renewals.

The board members reviewed a request made by Ms. Penttinen to hire a part-time administrative temp to assist her during the next few months when license renewal applications will be processed. She proposes to allow the position to work 10 to 15 hours per week as needed at a salary between $10 and $11 per hour. Dr. Kaplan stated that the board had done this in the past and he would agree with doing so again.

MOTION: Dr. Kaplan moved to allow the hiring of part-time temporary staff as outlined above. Dr. Leonetti seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

c. Executive Director's annual leave balance and carry-over amount.

The board members reviewed the report submitted by Ms. Penttinen which indicates that she will have an excess of unused vacation time at the end of this calendar year. Ms. Penttinen explained that vacation time is accrued from the first day of employment. Employees are permitted to carry over unused

vacation time each calendar year until they reach the maximum carryover of 320 hours. As of today, and vacation leave accrual through the end of the calendar year, Ms. Penttinen would have approximately 132 hours, (approximately 19 days), which she would lose if she does not use them. Ms. Penttinen had submitted a calendar for the remainder of 2012 to the board members indicating proposed vacation days. Most of those days would be taken on a Friday or Monday or immediately prior to or following a state holiday.

MOTION: Dr. Kaplan moved to approve the vacation schedule proposed by Ms. Penttinen. Dr. Campbell seconded the motion.
DISCUSSION: Mr. Rhodes asked Ms. Penttinen to clarify her vacation calendaras it appears she would still have two days unused. Ms. Penttinen explained that she had left this proposed schedule somewhat flexible because she was uncertain if she was going to need leave time during the summer for knee surgery. She stated that one or two days lost would be okay but she did not want to lose all 19 days. There was no further discussion on the motion.
VOTE: The motion passed unanimously by voice vote.

Following the vote Dr. Kaplan asked Ms. Penttinen if the board members should retain the calendar she has provided them. Ms. Penttinen stated that she will advise the board members prior to vacation days via e-mail and will also make sure to update her e-mail auto reply and voicemail greetings.

d. Legislative update.
   i. HB 2236 (Podiatry services and AHCCCS.)
   ii. HB 2244 (Composition of boards and commissions.)
   iii. SB 1189 (Out-of-state practitioners and free medical clinics.)

Ms. Penttinen advised that HB 2236 never made it out of committee. It had been assigned to the Appropriations Committee but the chair of that committee never placed it on a committee agenda, so it was never heard. However, she has spoken with Joe Abate who advised her that this could be anchored into the overall budget bill and that it does have a lot of support in the legislature. Regarding HB 2244, Ms. Penttinen advised that it also had died in committee. And for SB 1189, Ms. Penttinen had provided the board members with the most recent version of the bill which had been amended in many areas. The amendments have addressed or corrected the concerns raised by this board in the bill's original version. The bill has already passed completely through the Senate and is moving quickly through the House. Dr. Kaplan asked about disciplinary authority for podiatrists who are not licensed in Arizona. Ms. Penttinen advised that the Arizona Department of Health Services has been granted authority to investigate and discipline health care practitioners were not licensed in Arizona.

e. Malpractice case report.
   i. Kevin O'Brien, DPM: Claim from patient J.A. filed on 05/05/2010 and settled on 02/20/2012. (Board case previously investigated under case number 09-42-C and dismissed.)

The board members reviewed the PICA report and considered that they have previously reviewed this matter; therefore, no further action will be taken at this time.

IX. Call To The Public

There were no requests to speak during the Call to the Public.

X. Next Board Meeting Date:

a. May 9, 2012 at 8:30 a.m.

XI. Adjournment

MOTION: Dr. Kaplan moved to adjourn the meeting. Dr. Leonetti seconded the motion.
DISCUSSION: There was no discussion on the motion.
VOTE: The motion passed unanimously by voice vote and the meeting was adjourned at 11:24 AM.

STATE OF ARIZONA BOARD OF PODIATRY EXAMINERS

April 11, 2012; 8:30 a.m.
1400 West Washington St., B1
Phoenix, AZ 85007

Board Members:

Barry Kaplan, D.P.M, President
Joseph Leonetti, D.P.M., Member
Barbara Campbell, D.P.M., Member
M. Elizabeth Miles, Secretary-Treasurer
John Rhodes, Public Member

Staff: Sarah Penttinen, Executive Director

Assistant Attorney General: Marc Harris

Solicitor General: Chris Munns

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DR. KAPLAN: I'd like to call to order the State of Arizona Board of Podiatry Examiners meeting April 11, 2012, at 8:30 a.m.

Roll call: John Rhodes?

MR. RHODES: Here.

DR. KAPLAN: Liz Miles?

MS. MILES: Here.

DR. KAPLAN: Dr. Campbell?

DR. CAMPBELL: Here.

DR. KAPLAN: Barry Kaplan, here.

Dr. Leonetti?

DR. LEONETTI: Here.

DR. KAPLAN: Okay. All members are present, along with our staff, Sarah Penttinen, Executive Director, and Assistant Attorney General --

MR. MUNNS: Marc Harris will be the representing attorney for the State, and I'll advise the Board during the hearing.

MR. KAPLAN: We'll go to approval of the minutes for regular session of March 14th. Is there a motion to approve?

MS. MILES: One correction, page 7 of 12.

DR. KAPLAN: Page 7.

MS. MILES: In the paragraph that's

under the word "vote" in the middle of the page --

MS. PENTTINEN: Hold on. I'm still getting there.

MS. MILES: Last sentence in that paragraph, "They were devised." It should be advised.

MS. PENTTINEN: Okay. Gotcha.

MS. MILES: That's it. Move to approve with that correction.

DR. CAMPBELL: I have a couple --

DR. KAPLAN: Oh, you have --

DR. CAMPBELL: There is a couple of typos. On page two of 12 at the bottom, last paragraph, it looks like "talar dome" is spelled wrong. There are several areas where "talar" is misspelled.

MS. PENTTINEN: Where are we at now?

DR. CAMPBELL: Go to the fourth row from the bottom on page 2 of 12.

MS. PENTTINEN: How is it?

DR. CAMPBELL: T-A-L-A-R. Dr. Leonetti pointed out "ap gap" should be "a gap," and then Dr. DiNucci's name is misspelled on page 4 of 12.

MS. PENTTINEN: I'm sorry, page 4?

DR. CAMPBELL: Yes, the third line down from the top.

MS. PENTTINEN: Gotcha. Any others?

DR. CAMPBELL: I think that's it.

DR. KAPLAN: The motion is to approve the minutes with all corrections?

MS. MILES: Exactly.

DR. KAPLAN: Is there a second?

DR. CAMPBELL: Second.

DR. KAPLAN: All in favor?

(The board members answered aye.)

DR. KAPLAN: All opposed?

(No response.)

DR. KAPLAN: Roman Numeral IV, Review of Administrative Law Judge decision. This is a time-specific agenda item scheduled for 8:30. 11-43B, Elaine Shapiro, DPM, review of the Administrative Law Judge recommended decision regarding allegation of habitual substance abuse, use of controlled substances for other than accepted therapeutic purposes, violation of stipulated agreement with the Board, and failure to report criminal charges pursuant to ARS 32-3208.

This is the time for consideration of the Administrative Law Judge's recommended decision in case number 11A-11-42-3-POD, the matter regarding license number 0174 issued to Elaine J. Shapiro, DPM.

Are all the parties present that represented the State, and Dr. Shapiro?

MS. PENTTINEN: For the record, Dr. Shapiro is present.

MS. MILES: This is Case 12A-1143B. Right?

DR. KAPLAN: I have 11 on my --

MS. PENTTINEN: It should be 12A. That may have been a typo.

DR. KAPLAN: That was a typo? I'm sorry.

MS. PENTTINEN: I apologize.

MS. MILES: That's all right. I just wanted to make sure for purposes of the record.

DR. KAPLAN: Yeah, 12A.

Does our AG representative wish to introduce himself for the record?

MR. MUNNS: Chris Munns, advisor for the Board.

DR. KAPLAN: Okay. We are here with a court reporter. Does the court reporter have to swear in anybody or get their names or anything?

MR. MUNNS: Not at a venture hearing.

DR. KAPLAN: Okay, thank you.

MR. MUNNS: Do you want to have the

parties introduce themselves for the record?

DR. KAPLAN: Yes. Well, let me just finish this. The Board will now hear a brief oral argument from the parties on the ALJ's recommended decision. Mr. Harris is going to represent the Board, and he has a lot to say as far as that is concerned. Correct?

MR. HARRIS: Yes.

DR. KAPLAN: My concern is do we give him five minutes, or the same for both of them?

MR. MUNNS: It will be the same for both of them, and it's going to be at the Chair's discretion. A lot of boards do five minutes, ten minutes.

DR. KAPLAN: How much time do you think you would need to present?

MR. HARRIS: I think five minutes is more than sufficient.

DR. KAPLAN: Okay. And five minutes for Dr. Shapiro.

MR. HARRIS: Thank you.

Dr. Kaplan, members of the Board, I hope that you have a copy of the Administrative Law Judge's decision before you. The State respectfully requests that you adopt as your final order the ALJ's

recommendation in total. I believe that it accurately reflects the events that took place.

Very briefly, your Executive Director had a conversation with Dr. Shapiro the second week of December. In that conversation, it was apparent to Ms. Penttinen that Dr. Shapiro just wasn't right. That triggered a series of events that led to this Board calling a special meeting on December 30th to consider the summary suspension of Dr. Shapiro's license. At that time, Dr. Shapiro was under a consent agreement. One of the terms of the consent agreement was that she participate in a monitored aftercare program because she has had a history of substance abuse, specifically prescription drug abuse. This was the second consent agreement that the Board had entered into with Dr. Shapiro regarding this type of issue.

During the month of December, a number of facts were discovered by Ms. Penttinen that was presented to the Board for its consideration. One of those facts was that after Dr. Shapiro and Ms. Penttinen had that conversation, it was discovered that Dr. Shapiro was involved in a single car accident in Tucson. It was noted that that accident took place in the early morning hours, that Dr. Shapiro was on

her way to the office, and she was cited for, among other things, being slightly impaired. It was also discovered by Dr. Sucher that she was no longer participating in the monitored aftercare program consistent with the terms of the consent agreement. It was Dr. Sucher's opinion at the time that Dr. Shapiro had relapsed. He also conducted a pharmacy survey, and it was discovered that about -- for approximately the 12 months prior to Dr. Shapiro having the automobile accident, she had received prescription medications from seven different health care providers.

All of this information was presented to you, including the fact that approximately a week before you convened to consider the summary suspension of Dr. Shapiro's license, Dr. Shapiro had checked herself into a rehab facility in Tucson. You considered all of this information. You voted to summarily suspend her license.

This matter then proceeded to a formal administrative hearing. That hearing took place in February.

In the interim, I think it's important to note a couple of events. One, Dr. Shapiro upon receiving confirmation that the Board had summarily

suspended her license checked herself out of Sierra Tucson, against all medical providers' directions.

MS. PENTTINEN: Just for the record, Cottonwood.

MR. HARRIS: Cottonwood, thank you.

And then the Board received a letter from Dr. Sucher basically updating his knowledge and involvement with Dr. Shapiro since the Board had summarily suspended her license, and he indicated that it was his opinion that because she had discharged herself from the rehab facility that she was not actively participating in any type of treatment program, that he believed that she was not safe to practice, and that he was no longer providing any oversight or ongoing supervision consistent with the terms of the consent agreement. All this was documented, all this information was presented at the formal administrative hearing.

At the formal administrative hearing, Dr. Shapiro did not appear, and she was not represented. I believe that the ALJ's decision is an accurate account of all of the evidence and information that was presented, both before you at your meeting on December 30th and at the administrative hearing.

I believe that you have a record before you today that demonstrates a number of things. One, that it is unclear whether Dr. Shapiro is seeking any active treatment that would provide you with the confidence that she is safe to engage in the practice of podiatry, that there is no question that she violated the statutes that were set forth in the Notice of Hearing and that are reflected in the ALJ's decision. Amongst those were the failure to report habitual abuse of substances and a record that demonstrates her inability to safely and competently practice. It is for all of these reasons that I ask again that you adopt in total the ALJ's decision.

I would be more than happy to answer any questions that you may have of me at this time. Thank you.

DR. KAPLAN: Would you want to answer questions now, or would you like to hear Dr. Shapiro first?

MR. HARRIS: That would be fine, and at any time I would be more than happy to entertain questions. Thank you.

DR. KAPLAN: Unless anybody has questions of Mr. Harris right now?

(No response.)

DR. KAPLAN: Dr. Shapiro?

DR. SHAPIRO: I have some handouts that I talked to Sarah about, and I'd like to have each of you have copies of this.

DR. KAPLAN: Hold on. I'd like to ask a question, if we're allowed to accept and read handouts at this time, or was this something that should have been done at the ALJ's hearing?

MR. MUNNS: The Board is only allowed to consider evidence that was presented at the hearing, so it's only if it's a document that was admitted into the hearing as evidence. That's all the Board can consider, so if that wasn't admitted as evidence, the Board can't look at it. The Board can't consider any information that's not in the record. The hearing was the time for information to be put into the record for the Board to consider, and so that's how it works.

DR. KAPLAN: Thank you.

DR. SHAPIRO: I had viral encephalitis in '97 and have been treated with immunosuppressant medications. And right around, I would say, the early part of November, I started to feel unwell. And I want to make it clear, though, before I go on that I am here with expectations that are basically -- my priority is the truth, and I want to explain what

happened. I had a latent form of encephalitis, which not many people know about. But the appearance of one who has encephalitis, it very much looks like a drug and alcohol problem where you slur your words, your gait has an ataxic kind of appearance. It definitely does look like drugs and alcohol. And if you go on the website, you'll see that it's one of those misdiagnosed diseases.

In any case, I was diagnosed with latent encephalitis, and I was advised by my prior physician not to go to the Board -- I mean to the administrative hearing because latent encephalitis is triggered by stress, and he just felt that in looking at my safety, he did not want me to go up. He wrote -- I don't know -- I sent it to the Board and he sent it to the Board a six-page letter about my history of the encephalitis. And then I went to UMC and had basically the expert on encephalitis do a consultation on February 6th of 2012, at which time she found that I not only had encephalitis but also had meningitis.

And the night of December 9th when I was driving and I hit a cone in the road, I was stopped by a sheriff. I didn't know my name. I didn't know where I lived. I was tested for alcohol. That was zero. I then was taken to the sheriff's office.

Blood was drawn.

DR. LEONETTI: Did you say the night of or the morning of?

DR. SHAPIRO: Well, it was 5 a.m., so...

DR. LEONETTI: I would consider that the morning.

DR. SHAPIRO: Blood was drawn specifically to find out if there was any drugs in my system. That process is very lengthy in terms of getting results, of which we don't have yet. So I, on my own, went for a hair test, which actually is more specific than a blood test, and --

DR. KAPLAN: That was not part of the information administered at the hearing or given at the hearing, so I don't know that that pertains right now.

DR. SHAPIRO: Well, it shows that I never went over the limit of the therapeutic dose of any medication, that if I relapsed those figures would be very high. They reflect the last 190 days, which includes that period of time.

DR. KAPLAN: But that was a test that you did on your own. That was not a test that the Board did.

DR. SHAPIRO: Yes, but I did it at one

of the facilities that the Sucher Greenberg group --

DR. KAPLAN: But the Board didn't request that, and it wasn't presented at the hearing.

DR. SHAPIRO: Right. That's because I'm not here --

DR. KAPLAN: The rules were -- and I don't mean to keep interrupting you -- but the rules were whatever was presented at the hearing is what you can discuss today, and that was not discussed at the hearing.

DR. SHAPIRO: Well, my physician didn't allow me to go to that hearing, and I felt like I had to follow my physician's advice.

DR. KAPLAN: This is -- Dr. Leonetti?

DR. LEONETTI: This was for Mr. Harris. What was actually presented at the hearing on Dr. Shapiro's behalf?

MR. HARRIS: I don't believe anything was presented on behalf of Dr. Shapiro. I can tell you what the State presented, and I'm hoping that you have a copy of those.

DR. LEONETTI: We do. We do have that, but I wasn't sure if there was anybody that submitted anything -- I know Dr. Shapiro wasn't there, but I wasn't sure if there was anything submitted on her

behalf.

MR. HARRIS: No.

DR. SHAPIRO: I submitted this much information to the hearing (indicating).

MS. PENTTINEN: No.

MR. MUNNS: Mr. President, if you want to go into executive session for legal advice, I can do that, or I can do it in open session.

DR. KAPLAN: Do it in open session.

MR. MUNNS: Okay. Go ahead. I'll let Mr. Harris finish.

MR. HARRIS: I just want to point out that according to the ALJ's decision, apparently Dr. Shapiro submitted some information to the office of administrative hearings. However, and I'm reading on page 3 of that decision, footnote one, that it was not considered because it was not offered at the time of hearing. I'm not sure if -- what information. I haven't received any information.

I would also like to point out that at no time prior to the administrative hearing did Dr. Shapiro ask for a continuance based upon a medical necessity or was there a note from her doctor indicating that she was not physically able to participate at the administrative hearing, so this is

all information that the State is hearing for the first time this morning.

DR. SHAPIRO: Well, I was in his office when I saw him put it in an envelope addressed to the Administrative Judge and to the Board. And in that letter, it specifically says that he does not feel that I should go up to the hearing.

DR. KAPLAN: If it was not received, and apparently it was received afterwards, then --

DR. SHAPIRO: No. It was not received afterwards.

MS. PENTTINEN: From an administrative standpoint, I can verify that -- Dr. Shapiro, I believe this is the packet of information you're discussing. Is that from your primary care physician?

DR. SHAPIRO: Yes.

MS. PENTTINEN: It was copies of medical records with notes inserted into them, tabs and stickers placed upon them with Dr. Shapiro's personal notes about her chart, and a letter from her physician that states what was going on based on what Dr. Shapiro had reported to him. I did turn that evidence over to the attorney general representative in this case for his determination of its value at the hearing.

DR. LEONETTI: What time frame was that?

MS. PENTTINEN: It was prior to the fall hearing.

DR. KAPLAN: Okay. Thank you for that.

DR. SHAPIRO: That is completely untrue.

DR. KAPLAN: We're running out of time, so if you have a conclusion to your presentation or wish to answer questions, which I have one for you --

DR. SHAPIRO: Well, one big part of what I read was that a comment was made about that I was going to multiple doctors seeking medication, and I want to go over -- because it is in my notes, and I feel that it is important to note that I had a dermatological procedure where I received three Valiums and ten Lortabs.

DR. KAPLAN: Dr. Shapiro, what was presented, if I'm correct, was the pharmacy report, a pharmaceutical report.

DR. SHAPIRO: I have it. I have the readout.

DR. KAPLAN: So we have the entire report. We reviewed the entire report. We reviewed all of the doctors that were on that report. And it's a report that indicates everything that was dispensed to you during that period of time.

DR. SHAPIRO: But, for instance, the number of doctors that are mentioned, two of them are nurse practitioners to that physician.

DR. KAPLAN: We understand that.

DR. SHAPIRO: And they are extremely small amounts, and they were right after a procedure for pain for a very short period of time.

DR. KAPLAN: We understand that.

DR. SHAPIRO: And I told Dr. Sucher and Subbureddiar. I got permission for that, everything I ever did that involved any medication whatsoever. And, you know, this whole kind of attitude about what went on seems to lack the most important part, which is I was suffering from a very serious disease entity that causes one to appear drunk and/or having taken drugs, and that just didn't happen. And I feel that the hair is very, very -- I mean, because I didn't present it to the hearing because my doctor told me not to go up, and that's negated when that shows that I never went above the therapeutic dose on any of the medications that are looked for.

DR. KAPLAN: Okay. We're going to stop, because we have all that.

DR. SHAPIRO: We don't have that. You don't have the hair thing. I just got it.

DR. KAPLAN: That's not part of the information that was presented to the ALJ. That has nothing to do with the hearing.

DR. SHAPIRO: That's why I said it. I'm here to say my truth. I have no expectation of getting back my license or anything like that. I'm here because I feel that I have not been represented in terms of what actually occurred.

MS. MILES: Dr. Shapiro, your time to do that was at the administrative hearing.

DR. SHAPIRO: I know. And I was told at the time my physician did not want me to go. This is not just a two-day problem.

MS. MILES: There is absolutely not one shred of evidence in this record, not one shred of any of that information, therefore I will not consider it. The time to submit that evidence was at the hearing.

DR. SHAPIRO: I submitted this.

MS. MILES: It was not submitted to the hearing so --

DR. KAPLAN: Dr. Shapiro --

MS. MILES: -- it will not be considered.

DR. KAPLAN: Dr. Shapiro, you're out of order right now. The argument doesn't stand right

now.

But my question is, just for clarification, when was the last time you had a test to indicate you had latent viral encephalitis?

DR. SHAPIRO: Well, the only test for that is a spinal tap, and --

MS. MILES: Excuse me. Dr. Kaplan, I'd like to get some legal advice in executive session, please.

DR. KAPLAN: Sure.

DR. SHAPIRO: But I would like to --

DR. KAPLAN: There was a request to move into executive session. All in favor?

(The board members answered aye.)

DR. LEONETTI: I second.

DR. KAPLAN: We're going into executive session.

DR. SHAPIRO: Well, I would like this to be submitted because it was given prior to the hearing.

DR. KAPLAN: Dr. Shapiro, we are not in session.

(Executive session was held from 8:55 a.m. to 9:02 a.m.)

MS. PENTTINEN: Okay. We are back in

regular session at 9:02.

DR. KAPLAN: We're back on the record. And it is my decision that oral arguments have been heard from both Mr. Harris and Dr. Shapiro, and we are going to move on, unless there are any other statements from the Board that wish to be made at this point.

(No response.)

DR. KAPLAN: Okay. So having reviewed the Administrative Law Judge's proposed findings of fact, conclusions of law and order in this case, the record provided us and the arguments from the parties, the Board will now discuss its decision. There will be no further comments from anyone at this time during our discussion.

Do you have any statements that you would like to make?

MS. MILES: I just want to say that I have reviewed all the records in this case, including all the exhibits submitted at the hearing. And one of the exhibits submitted at the hearing, there is evidence of another disease process mentioned by Dr. Shapiro about the encephalitis, so that was presented within some of the medical records provided, so that is known to the Board in terms of in the

hearing in the exhibits presented.

I am not considering any other outside evidence attempted to be presented at the meeting today. I believe that Dr. Shapiro, after listening to the hearing and reviewing all of the evidence, was absolutely properly noticed of the hearing. There was not anything submitted on the day of the hearing or even the day before, the day after, a very short period of time, indicating that she had been medically advised not to attend the hearing. That was not submitted to the Administrative Law Judge, and I find that there is no evidence that that was the case.

DR. SHAPIRO: May I say one thing?

DR. KAPLAN: There is no discussion. I'm sorry.

DR. SHAPIRO: I called the day before.

MS. MILES: There is evidence in the Administrative Law Judge's recommendation that approximately a little bit over a week after the hearing information was submitted to the Administrative Law Judge. The hearing record at that point was closed, and that information was not considered. And I believe that that's appropriate procedurally and substantively for purposes of the Administrative Law Judge.

Based on the record as it appears and the decision received by the Administrative Law Judge, I move to accept the findings of fact, the recommendations in the Recommended Findings of Fact 1 through 18 of the Administrative Law Judge decision.

DR. KAPLAN: Second?

DR. LEONETTI: I'll second it.

DR. KAPLAN: We will have discussion now that I would also recommend the option to adopt the findings of fact as drafted, which is from the Administrative Law Judge to revoke the license of Dr. Shapiro.

MR. MUNNS: Mr. President, we're going to do it in three steps, so we'll have to vote on that motion first.

DR. KAPLAN: So there is a motion to adopt the findings of fact as drafted. Is there a second?

DR. LEONETTI: Second.

DR. KAPLAN: All in favor?

(The board members answered aye.)

DR. KAPLAN: All opposed?

(No response.)

MS. MILES: Mr. Chairman, I move to accept the recommended conclusions of law numbers 1

through 9.

DR. LEONETTI: Second.

DR. KAPLAN: All in favor?

(The board members answered aye.)

DR. KAPLAN: All opposed?

(No response.)

MS. MILES: Mr. Chairman, I also recommend that we adopt the recommended order in this particular case affirming the summary suspension of Dr. Shapiro's license and revoking her license to practice podiatry.

DR. KAPLAN: Is there a second?

MR. RHODES: Second.

DR. KAPLAN: All in favor?

(The board members answered aye.)

DR. KAPLAN: Opposed?

MR. MUNNS: You'll need a roll call on that one.

DR. KAPLAN: Mr. Rhodes?

MR. RHODES: Aye.

DR. KAPLAN: Ms. Miles?

MS. MILES: Aye.

DR. KAPLAN: Dr. Campbell?

DR. CAMPBELL: Aye.

DR. KAPLAN: Dr. Leonetti?

DR. LEONETTI: Aye.

DR. KAPLAN: Dr. Kaplan, aye. So the matter is voted for revocation of license number 0174 issued to Elaine J. Shapiro, DPM.

Thank you very much.

(The proceeding concluded at 9:05 a.m.)

C E R T I F I C A T E

I HEREBY CERTIFY that the proceedings had upon the foregoing hearing are contained in the shorthand record made by me thereof, and that the foregoing 25 pages constitute a full, true, and correct transcript of said shorthand record, all done to the best of my skill and ability.

DATED at Phoenix, Arizona, this 24th day of April, 2012.

Deborah L. Wilks
Certified Court Reporter
Certificate No. 50849